Authorization of
Release/Request of Information

Location of protective health information.

Name of Entity: _____

Address: _____

_____

City: _____ **State:** _____ **Zip:** _____

Date of Service: _____

SS#: _____ **ID#:**_____

Name: _____

Address: _____

_____

Ph: _____ **DOB:**_____

Sex: _____ **Race:** _____ **Marital Status:** _____

I hereby authorize the release of the following health information only to:

Name of Individual/Entity: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Covering the period of health care from (date) _____ to (date) _____.
The purpose of this request or disclosure is _____.
This authorization shall be limited to health information pertaining to the following: (check if applicable)

	Breast & Cervical		Family Planning		Maternity/Prenatal
	Child Health		Financial Records		Medical History*
	Complete Medical Record		Genetics		Medication Records
	Consultation Reports*		HIV/AIDS		Progress Notes*
	Diabetes		Hospitalization		STD (other than HIV/AIDS)
	Early Intervention		Hypertension		**Job Related (specify)
	EPSDT		Laboratory Test*		
For CMP Use:			Other (specify)		

* Identify Program by Name
** Medical information pertaining to treatment or a condition that is related to absence from work, return to work, and/or any specific restrictions such as but not limited to typing, physical locomotion, driving, lifting, standing or sitting.

I understand that I may revoke this authorization at any time except to the extent that action has been taken thereon. I further understand that this authorization will expire in 90 days from the date below. For Early Interventions records only, this authorization will expire in 6 months from the date below.

_____ Date: _____
Individual or Representative's Signature (If patient's representative signs, please identify authority to act for the patient).

_____ Date: _____
Signature of Health Department Representative

Confidentiality Note: This information has been disclosed to you from records whose confidentiality is protected. Statutes/Regulations prohibit you from making further disclosures other than treatment, payment or health care operations, without the specific written authorization of the person to whom it pertains, or as otherwise permitted by such regulations. Alcohol and drug abuse information, if present, has been disclosed from records whose confidentiality is protected by Federal Laws. Federal Regulations (42 CFR, Part II) prohibits making any further disclosure of it without the specific written authorization of the undersigned or as otherwise permitted by such regulations. For Early Intervention records, all provisions of the Family Educational Rights and Privacy Act (34 CFR, Part 99) and federal regulations pertaining to Early Intervention apply.

MSDH use only
PHI request sent - Date: _____ Initials: _____
PHI released from Health Department - Date: _____ Initials: _____